Taking Promises to Impact: Definable Actions for a Healthier Rural America

A Strategic Plan

A Healthier *WE*

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A Healthier WE - a 501(c) 3 non-profit organization dedicated to addressing critical issues in rural health

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Introduction

A Healthier WE is dedicated to transforming rural health by creating a nationally engaged community that cultivates innovation and civil dialogue around the most pressing issues and opportunities affecting rural health and well-being, while connecting and amplifying the voices and programs bringing change.

Founded in 2018, A Healthier WE is a 501(c)3 non-profit organization with a vision to become a leading rural health catalyst for finding solutions and opportunities through cooperation, innovation and committed leadership for the technology and health economies in rural communities.

In March 2019, AHW hosted the Healthier Rural America Summit in Salt Lake City, with a view to bring together regional and national leaders across a variety of rural community-focused disciplines to discuss, debate and deliver new and innovative rural health initiatives. The Summit aimed to address many key challenges by offering an inspiring vision of rural cooperation and leadership in the coming information and health economies. From the many thoughtful initiatives that were presented, one message predominated: the need for transformative change to transition from hope to action.

This briefing paper continues where the Summit left off. It identifies five distinct programmatic areas - along with potential collaborative and funding partners - that AHW can build from in moving rural America and its citizens forward using a more holistic approach to promote communities of healthy living.

Methodology

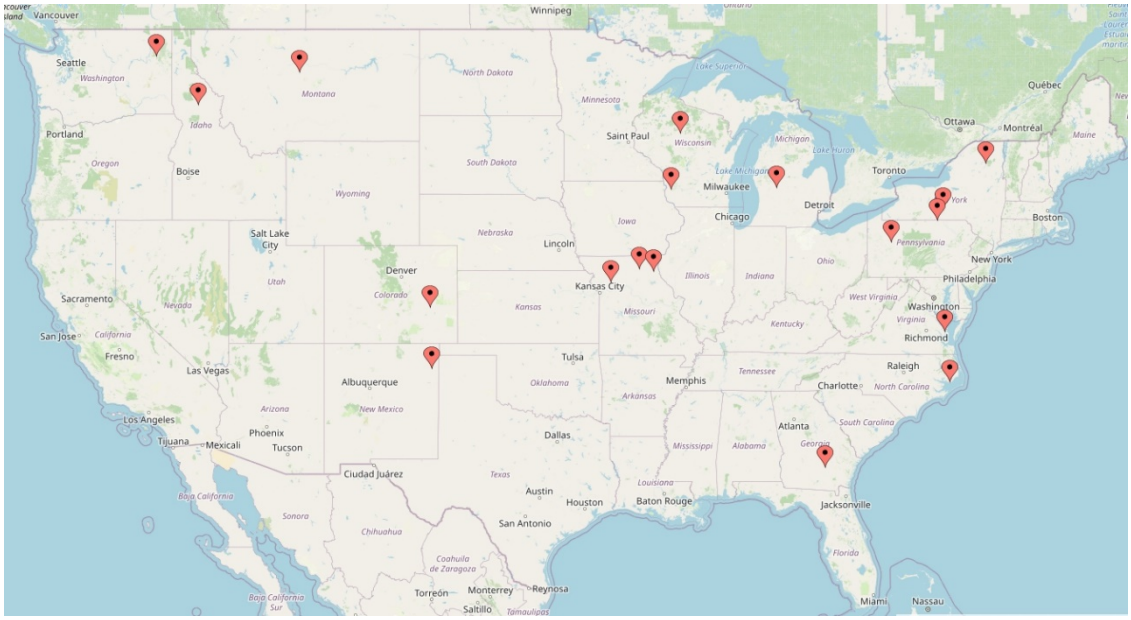
To inform future strategic directions and partnerships, we utilized a 'positive outlier' methodology to identify rural communities in the United States who were both above-average on measures of deprivation, but simultaneously ranked highly on a key health indicator (years of potential life lost rate, hereinafter YLL – because YLLs are a negative health indicator, counties were ranked in ascending order of YLL, with the lowest YLL scores deemed best). These data were sourced from the University of Wisconsin Population Health Institute's County Health Rankings & Roadmaps, which were subsequently filtered and sorted to account for socio-economic factors. The 2021 County Health Rankings bases its 'health outcomes' assessment on two focus areas: length of life and quality of life. The quality of life metric was itself a composite of three separate self-reported assessments of health sourced from Behavioral Risk Factor Surveillance System telephone surveys (age-adjusted reports of 'fair' or 'poor' health, poor physical health days, and poor mental health days) plus the percentage of live births with low birthweight. In the aggregate, these metrics were weighted at 50% of the total health outcomes score; the other 50% of the weighting was from YLLs. Because subjective, self-reported health status data are frequently unreliable, and owing to the greatest single weighting deriving from more objective National Center for Health Statistics Mortality Files, counties from the UWPHI dataset were ranked on this 'length of life' focus area using the YLL variable, and then filtered to only include counties with higher-than-median percentages of children in poverty. The result is a list of counties who might otherwise be expected to have poor health status and projections owing to high percentages of poverty,

but in fact manage to manifest high levels of health in terms of a robust health outcome (i.e., avoiding premature death).

This methodology was chosen because of a confluence of factors, including international recognition and comparability, data quality (availability and reliability), correlation with health system functioning, and predictive value for future health status[1]. It should be noted that this methodology does not assert causation and only represents a snapshot in time. Because the purpose of this planning exercise was to identify those communities who represent success stories that may be fertile ground for emulation and/or collaboration, we have not attempted to undertake time series analyses or otherwise ascertain underlying reasons or patterns associated with positive outlier-hood. It should be acknowledged that the priorities of high-performing counties may diverge from those of low-performing counties as a reflection of demographic differences, community priorities, and/or history, and that adoption of these themes by others mightn't necessarily result in improvements in health. Nonetheless, it serves as a quantitative insight into shared priorities by rural counties who are succeeding against the odds.

Using the positive outlier methodology, the following 18 counties were identified (in order from lowest YLL rate to highest):

Vernon County, WI
Forest County, PA
Daviess County, MO
Clark County, MO
Chouteau County, MT
Wheeler County, GA
Lincoln County, CO
Mecosta County, MI
Franklin County, NY
Price County, WI
Schuyler County, NY
Clearwater County, ID
Tyrrell County, NC
Cayuga County, NY
Schuyler County, MO
Stevens County, WA
Union County, NM
Northumberland County, VA



[1] It was important to control for socio-economic status, as simply ranking on health status among rural counties in the US results in a badly unrepresentative cohort of counties being identified. Using a simple health status ranking methodology – with no control for socioeconomic status - results in the following top 20: 1) Pitkin County, CO; 2) San Juan County, WA; 3) Routt County, CO; 4) Winneshiek County, IA; 5) Summit County, UT; 6) Teton County, WY; 7) Sioux County, IA; 8) San Miguel County, CO; 9) Nantucket County, MA; 10) Mono County, CA; 11) Addison County, VT; 12) Cook County, MN; 13) Morgan County, UT; 14) Valley County, ID; 15) Pierce County, NE; 16) Valley County, NE; 17) Marion County, IA; 18) Archuleta County, CO; 19) Cedar County, NE; 20) Gunnison County, CO. N.B. Pitkin Co, CO = Aspen; San Juan Co, WA = wealthiest county in Washington; Summit Co, UT = Park City; Teton Co, WY = Jackson Hole; Nantucket Co, MA = wealthiest county in Massachusetts; San Miguel Co, CO = Telluride; Addison Co, VT = Middlebury college; Cook Co, MN = Grand Portage Indian Reservation + casino.

Though a significant portion of these communities come from 'purple' states in the Midwest and Eastern Seaboard, they embody a nationally representative, broad swath of community typologies, including working class country, African American south, Hispanic center, Rural Midwest, and Native American lands. This diversity is an important signifier of the variety of strategies that can be (and are being) pursued in service of rural health and suggest that 'one size fits all' solutions need to be leavened with community input and particulars.

After communities were identified and assessed for methodological fit, key themes were ascertained via research into community health assessments, county health department publications, state office of rural health reporting, community health surveys and community-wide strategic planning processes, NGO and university white papers, journal databases, and grey literature. For the most part, county themes come from community health needs assessments (CHNAs). The Affordable Care Act set out a requirement that Critical Access Hospitals (CAHs) conduct a CHNA every three years. This requirement is intended to create a framework for communities to prioritize health needs, as well as a process for addressing these identified needs. Though not every rural county below has a CAH, the CHNA process is also occasionally employed by county and state health departments, for-profit hospitals, academic research institutions and medical schools, private foundations, and non-governmental organizations. Where possible, key themes were taken from a county-specific CHNA. In some cases, themes were discerned from multi-county CHNAs (or the like, such as with health needs implementation strategies or community health improvement plans), or statewide CHNAs with county-specific sub-sections.

From the 18 counties identified from the positive outlier methodology, the following themes were identified, organized in table form:

Key Themes from Positive Outlier Rural Counties

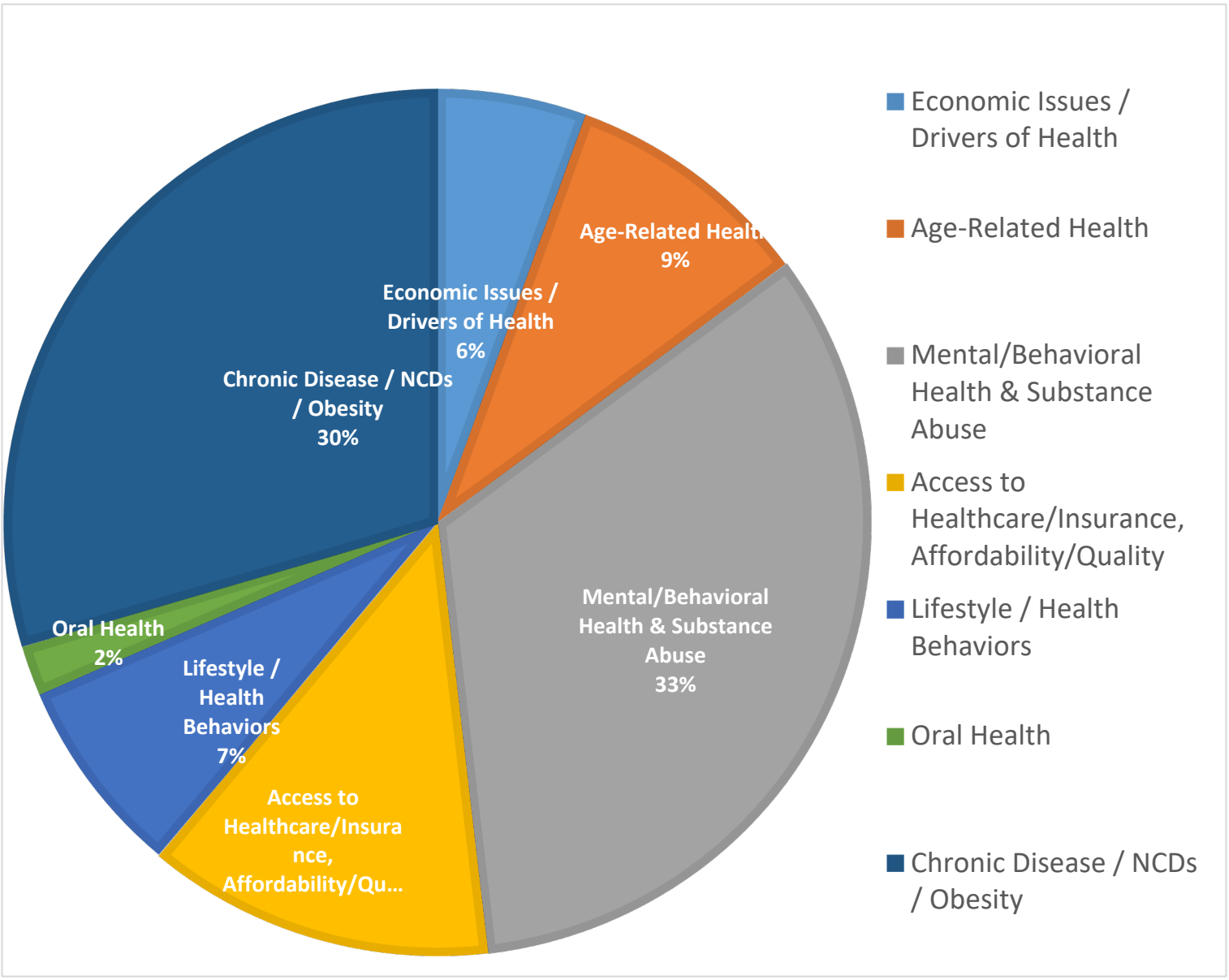
County	**Key Priority #1**	**Key Priority #2**	**Key Priority #3**	**Sources**
Vernon County, WI	Chronic disease and contributing factors	Mental health, behavioral health and substance abuse	Lifestyle factors (obesity, nutrition)	Gundersen St. Joseph's Hospital and Clinics Community Health Needs Implementation Strategy 2016 - 2018
Forest County, PA	Alcohol and drug use	Mental health	Chronic disease prevention and management	2016 Forest, Oneida, and Vilas Counties Community Health Needs Assessment
Daviess County, MO	Mental health services	Substance abuse	Health insurance coverage, availability, and affordability	Community Health Needs Assessment Cameron Regional Medical Center Clinton, Caldwell, DeKalb and Daviess County, MO
Clark County, MO	Chronic disease (obesity, hypertension, CVD, diabetes)	Mental health / substance misuse	Health behaviors / adolescent health	Scotland Health Care System 2019 Community Health Needs Assessment

				Implementation Outcomes
Chouteau County, MT	Physical activity	Obesity	Health care access	Chouteau County Community Health Improvement Plan
Wheeler County, GA	Chronic disease (diabetes, heart disease, stroke)	Nutrition, physical activity and overweight	Infant health / family planning	2020 Community Health Needs Assessment – Central Georgia
Lincoln County, CO	Substance use / mental health	Economic security	Access to primary and specialty care	2019 Community Health Needs Assessment - Kaiser Permanente Colorado
Mecosta County, MI	Health care access	Substance use and abuse	Obesity and weight	Mecosta County Medical Center Community Health Needs Assessment
Franklin County, NY	Chronic disease	Mental health	Substance Abuse	Franklin County 2019-2021 Community Health Assessment and Community Health Improvement Plan and Community Service Plan
Price County, WI	Alcohol and other drug abuse / mental health	Chronic disease prevention / nutrition and healthy foods	Geriatric health	Price County Community Health Needs Assessment and Improvement Plan
Schuyler County, NY	Chronic disease preventative care and management	Tobacco prevention / mental and substance use disorders	Healthy eating and food security	Schuyler County 2019-2021 Community Health Assessment (CHA), Community Service Plan (CSP) and Community Health Improvement Plan (CHIP)
Clearwater County, ID	NCDs (cancer, overweight / obesity / diabetes)	Mental health / suicide / tobacco	Child abuse / neglect	Community Health Assessment – Idaho North Central District
Tyrrell County, NC	NCDs (obesity, physical activity)	Substance misuse / mental health / suicide and broader injury prevention	Oral health	Tyrrell County 2018 Community Health Needs Assessment
Cayuga County, NY	Chronic disease prevention (healthy eating, food security)	Obesity and chronic disease	Child and adolescent health	Cayuga County 2019 Community Health Assessment; 2019-2021 Community Service Plan & Community Health Improvement Plan
Schuyler County, MO	NCDs (obesity / high cholesterol /	Smoking	Medicaid enrollment	Missouri Primary Care Needs Assessment 2020

	mammography / sigmoidoscopy and colonoscopy)			
Stevens County, WA	Behavioral health	Access to services	Early childhood support	Stevens County Community Health Needs Assessment 2016
Union County, NM	Access to health care (primary care, oral health, and specialty care services and providers)	Chronic disease prevention	Mental and behavioral health	Union County General Hospital Community Health Needs Assessment and Implementation Plan
Northumberland County, VA	Chronic disease	Behavioral health	Drivers of health	Bon Secours Richmond Health System Rappahannock General Hospital Community Health Needs Assessment 2019-2021

In the aggregate, some priorities are so common as to be essentially universal. Out of a total of 54 key priority areas, a third (18 instances of designation as a priority) referred to some permutation of mental health, behavioral health, or substance abuse (including the use of licit substances such as alcohol and tobacco, as well as illicit substances including opioids). Similarly, chronic diseases and non-communicable diseases, including obesity and diabetes, cardiovascular disease and cancer, nutrition and food security were designated a key priority 16 times. Access to healthcare and insurance, as well as the affordability of health insurance, were designated a key priority seven times; age-related health (adolescent health, teen pregnancies, and geriatric health) were highlighted five times; lifestyle choices and health behaviors (exercise and physical activity) were listed as a priority four times; broader drivers of health, including economic issues, were mentioned as a key priority three times; oral health was highlighted as a priority area once. Graphically, these can be represented thus:

Rural Areas of Need



This quantitative analysis gives an empirical basis for geographic and thematic emphases by A Healthier WE, but for the greatest chance to be tried and to become sustainable, these foci should be married with data on initiatives with demonstrated recent successes in attracting grants, public-private partnerships, notable accomplishments (e.g., inclusion in the National Academy of Medicine Culture of Health Success Stories), etc. By triangulating between those initiatives with a record of funding success, the geographic areas with an empirical basis for further investment (or conversely, which may be 'green fields' with little investment thus far), and the key priority areas identified by healthy rural communities, we can begin to delineate likely funding streams, potential partner organizations (including NGOs, state/county/municipal governments, private corporations and venture capital firms, etc.), and innovative initiatives that can form the backbone of a sustainable organizational strategy for A Healthier WE.

Taking Promises to Impact: Definable Action

The Healthier WE team has identified five primary program areas that may be considered in the pursuit of sustainability. These program areas have been chosen for their track record in attracting grant or venture capital funding, and for their alignment with empirically-derived geographic and/or thematic focus areas.

In greater detail, these program areas are as follows:

- Health Information technology (including public Wi-Fi) and the impact of broadband access on workforce and community economic development, including training via virtual reality and augmented reality (classroom and virtual)
- Food security / school lunch / critical access hospital provisioning initiatives predicated on local sourcing
- Broader mental health programming and workforce training, along with the need to address major causes of death: overweight/obesity, tobacco, substance abuse, and injury/violence/suicide
- Health sector innovative transformation / environmental health / climate change
- Knowledge transfer, including regional conference initiatives with narrower thematic and geographic foci

These areas of action are designed to assist local communities in becoming a healthy community thru work with identified leaders of each community. It should be noted that many of these program areas have potential overlaps with each other, and these symbioses could be leveraged to develop initiatives with higher probabilities of funding applications, partnerships, and efficacy. Each program area will be discussed in concert with potential partner organizations, likely funding streams, example initiatives that have been employed elsewhere, and next steps.

Health Information Technology; workforce and community economic development

Existing programs in this space include the Deloitte Center for Government Insights' 'Narrowing the rural-urban health divide – Bringing virtual health to rural communities' study, and HRSA's Office for the Advancement of Telehealth and its 12 regional and two national Telehealth Resource Centers (TRCs) – in particular the Telehealth Network Grant Program and the two Telehealth Focused Rural Health Research Centers. The College of Southern Nevada's Dialysis Patient Care Technician program, which trains via VR video and dialysis simulations, and Johns Hopkins University's VR nurse training modules are examples of programming that could be licensed or partnered with. Potential funding streams include USDA's BioPreferred Rural Development Business Program development loans and grants, the US Department of Labor's Employment and Training Administration grants for rural healthcare workforce shortage alleviation, and HRSA's Bureau of Health Workforce grants. In a similar vein, the Salvation Army Workforce Development Programs – incorporating life skills training (back to the basics like a resume, getting a driver's license, etc.) and working with corporations like UPS to hire those coming out of alcohol and drug addiction as trainees, working in conjunction with mental and behavioral health professionals to understand and change the root causes.

Examples of AR/VR initiatives include Lifeliqe, an education-focused VR company, which has launched a virtual reality training program (currently in stealth) to bring health and wellness related vocational training to rural and underserved communities and community colleges in the US. They recently won a $3 million workforce grant in Nevada and plan to roll this out in late 2021.

Last month, the Department of Health and Human Services announced that it was distributing nearly $20 million to strengthen telehealth services — usually medical appointments that take place by video or phone — in rural and underserved communities across the country. While the amount is relatively modest, it is part of a broader push to address the long-neglected health care infrastructure in those areas. According to the Brookings Institute there are up to 42 million Americans without broadband access in America. This may because it simply doesn't exist, or it does exist and is unaffordable. Currently programs across the US like Virtual Living Room and the Rural Health Telecom Program are working towards expanding broadband and are being funded by the FCC, Universal Services Admin Company, the Foundation for Rural Service and the Rural Broadband Association. Many states have added resources and more focus to this issue for rural areas.

Success stories

Local TELCOs and Public WIFI programs – Microsoft and the Public Library Association partnered to increase access to technology in rural communities.

Microsoft's Airband Initiative – Closing the rural broadband gap – this initiative aims to close the digital divide and bring high-speed internet connectivity to unconnected communities around the world. It officially launched in 2017 with the goal of bringing broadband connectivity to 2 million people in the U.S. by July 2022. After early success, that goal grew to 3 million people in the U.S. — and an additional 40 million across the globe — by the same deadline.

T-Mobile Mobile Hometown Initiative – bringing free WIFI to rural America. This new initiative will add internet access to rural homes, create jobs and invest billions to bring much needed internet connectivity, including 5G, to rural communities.

Cisco Rural Broadband Initiative - Cisco's open access approach to a converged network enables rural providers to connect their communities across any access infrastructure: mobile cell towers, telco/cable fixed line, or wireless last mile. The whole concept of more rural broadband is extremely important. America is moving into a world when both rural and urban Americans will be working from home and educating from home for the foreseeable future., The level of broadband connectivity available to an individual or household can greatly affect the quality of education, healthcare, and employment opportunities they receive. It can also hinder their ability to access other critical public services. As the world begins to move toward operating in a hybrid physical and virtual environment, those living in rural areas are at significant risk of being left behind by the accelerating disparities of the digital divide.

	Potential partner organizations	Example initiatives	Likely funding streams
Health workforce development	FORWARD NM Pathways to Health Careers (potential adjunct to Matt Probst's health workforce development initiatives)	NM Pathways to health careers pipeline	US Department of Labor's Employment and Training Administration grants for rural healthcare workforce shortage alleviation, HRSA's Bureau of Health Workforce grants
AR/VR training	Johns Hopkins University's VR nurse training modules (Johns Hopkins also collaborated with NRHA on the 2018 Rural Hospital CEO turnover study; the Center for Rural Health Leadership used the JH/NRHA study to inform the Rural Hospital Certification program)	Lifelique, College of Southern Nevada's Dialysis Patient Care Technician program,	The Mayday Fund for AR/VR/XR medical and public health applications, Optum Ventures VC – special focus on health and healthcare initiatives

Food security

Existing programs in this space range from school lunch reinvention to introduction of community gardens and food justice education and programs. According to the Food Research and Action Center, rural areas that grow most of our nation's food, households face considerably deeper struggles with hunger than those in metropolitan areas and 12.1% of rural households faced food insecurity in 2020, compared to 10.3% of households in metropolitan areas. Food insecurity is linked to a wide range of negative health outcomes, and rural Americans are at higher risk for poor health outcomes than their

urban counterparts. Many local community groups have formed inside churches, community centers and housing centers and could also become helpful partners.

Food is a household issue, but it is shaped by larger patterns of spatial inequality in our economy. Progress is being made in this area and numerous rural food security and nutritious food programs are getting funded, including: Blue Cross Blue Shield of Michigan Foundation's Michigan Building Healthy Communities Step Up for School Wellness Program , American Rescue Plan Act: Emergency Rural Health Care Grants, and Kansas Healthy Habits for Life.

Success stories

Fayette County, Kentucky Farm to School Program: Empowering youth to make healthy lifestyle choices by promoting the benefits of consuming locally grown and produced foods.

This district increased school meal participation by educating their students about the local, healthy options they were already sourcing from local Kentucky Farmers. Fayette County Public School's (FCPS) Nutrition Department (KY) worked closely with their Farm to School program to coordinate the Fayette Farm to School Challenge, a weeklong (continuing each year) program filled with taste tests, cafeteria guests and educational programs to help increase student participation. School meal participation increased drastically once students learned where their food came from. Rosa Parks Elementary increased meal participation 23 percent that week alone and participation at Sandersville Elementary has since increased by 15 percent.

From Catch to CHEF program in Oregon: Continued Approach to Child Health.

Childhood obesity was on the rise in Lincoln, Benton and Linn counties. To help children and families in Lincoln, rural Benton, and East Linn counties achieve higher-quality lives free from preventable disease related to poor nutrition and obesity, two programs were applied on a local level to provide nutrition physical activity and culinary education in a school and community setting. The results were encouraging. The physical activity rate surpassed the Department of Health and Human Services recommended rate by 5%, and schools started serving healthier options in their cafeterias. This program was funded by a Rural Health Network Development grant.

Williamson Wellness Center - addressing food insecurity and bringing healthy food education to Appalachia. They created a community garden, launched a farmers' market, and started a mobile healthy food drop off program to remote food insecure areas in Mingo County, West Virginia. This program was funded by a US Department of Labor 1.3 million dollar grant.

AmeriCorps VISTA Food Justice Program -This project's goal is to establish infrastructure that supports more nutritious food being available to people vulnerable to food insecurity and more people

participating in solving hunger. The VISTA program is active in a number of rural areas in America, ranging from Idaho to Maine.

Beyond Green Sustainable Food Partners' introduction of organic and locally grown food into lunch rooms, prisons, hospitals, and other charitable entities to create a model for an independent and sustainable economy. The program worked exclusively with local farmers and growers to purchase fresh foods and instruct the lunch ladies to cook farm to table school lunches from scratch for local rural schools. In the Hawaii Kohala School Complex, using a cooking from scratch fresh foods approach for school lunches, local food purchases increased from 20% to over 40%, fresh food purchases increased from 27% to 92%, and the school experienced an overall lunch program savings of 30%. BGSFP has done similar programs in rural New York and Illinois.

Broader mental health programming

Existing programming includes Project ECHO's initiative to increase the capacity of rural primary care providers for substance abuse patient management, in conjunction with pain and addiction specialists at affiliated university medical centers. Project Lazarus began in 2007 as a rural overdose prevention program in North Carolina but has now expanded to 24 states. It works on coalition formation / capacity building, chronic pain management and safe prescribing practices for providers, community-based medication disposal programs, naloxone distribution, and peer-guided recovery support. NIH has a current grant cycle on alcohol and other substance abuse education programs for health professionals, with funding to support creative educational activities with a primary focus on outreach to health professionals.

Mental Health First Aid is an 8-hour training course that originated in rural Australia that has since been adapted for use in 27 countries (including the US). It has trained over 150,000 rural Americans with appropriate strategies for helping others undergoing mental health crises, raised awareness of mental illnesses and treatments, and disseminated knowledge on rural mental health issues (through the MHFA for Rural Communities initiative). The Rural Community Paramedic Model should also be considered.

	Potential partner organizations	Example initiatives	Likely funding streams

Opioid / substance abuse	Project ECHO's 'become a partner' program.	Project Lazarus	NIH/NIAAA/NIDA 'Alcohol and Other Substance Use Research Education Programs for Health Professionals' grant cycle
Mental / behavioral health	National Association for Rural Mental Health (runs an annual conference and an academic journal)	Mental Health First Aid for Rural Communities initiative	NIH/NIMH 'Effectiveness of Implementing Sustainable Evidence-Based Mental Health Practices in Low-Resource Settings to Achieve Mental Health Equity for Traditionally Underserved Populations' grant,

Health sector innovative transformation / environmental health / climate change

Among positive outlier counties, quality-of-life, socioeconomic factors, and drivers of health were mentioned as a key priority area nearly 20% of the time in the aggregate. Because 'neighborhood and physical environment' are key drivers of health, socioeconomic status is strongly correlated with the physical environment and its quality, and the natural and living environments are fundamental quality-of-life indicators, environmental health is an implicit cornerstone of rural health. Though some aspects of environmental protection and environmental health have been politicized, even against a backdrop of rural COVID furor, matters like drinking water quality and other pillars of environmental protection are nearly unanimous in their approbation across the political spectrum. Though it may be euphemized via references to life quality and determinants of health, environmental protections – and ancillary considerations such as climate change and health sector sustainability – are the subjects of significant rural health programming and funding. Examples of programming in this area include: the West Virginia Rural Health Research Center, with a focus on rural environmental health, initially funded by a four-year Federal Office of Rural Health Policy cooperative agreement.

Similarly, the University of Iowa's Institute for Rural & Environmental Health endeavors to develop an internationally-recognized center for research and education in rural and environmental health. In August of 2021, HHS inaugurated the Office of Climate Change and Health Equity, tasked with fostering innovation in climate adaptation and resilience for disadvantaged communities and vulnerable populations (including rural and/or tribal populations), as well as promoting training opportunities to build the climate and health workforce and empower communities. Likely funders include USDA's climate hub, with current grant cycles including water and waste disposal technical assistance and training grants for rural areas, and Cooperative Extension System / land-grant university programs for building resilience to extreme weather events / climate change and general environmental protection.

Knowledge transfer, including regional conference initiatives with narrower thematic and geographic foci

The AHW team is looking to undertake an interactive innovative forum in rural health leadership, in states that are interested in creating an innovative approach to create local healthy communities. A potential one has been sited in Kentucky (locale TBD), intended to launch in early 2022 is an example of a regional conference initiative that AHW can pursue. Based on the agenda outline from the previously-mooted 2022 Healthier Rural America Summit, incorporating thematic content and success stories from the above empirical needs assessment, the forum would catalogue and present empathetic data-driven success stories.

AHW, having already identified barriers to skill development for those working in rural health, could function as a facilitator, utilizing abilities to provide opportunities and resources that enable progress and innovative disruption for those working in the rural health ecosphere. AHW can bring together content creators, grant writers, policy makers and industry leaders to create training seminars, webinars, podcasts and in-person training, to provide much-needed education focusing on where to find funding, how to secure funding, how to create powerful content that results in impact and partnerships, and how to engage communities to assist in meeting public health goals, to name just a few. These educational opportunities can also be offered as co-located events within existing larger events such as APHA, NRHA, as well as regional and state rural health meetings.

Funding would be secured via broad-based public/private sponsorships, with an expected attendant base comprised of participants from a diverse array of organizations and stakeholder backgrounds and will take place in the fertile ground where bottom-up and top-down community initiatives meet. The forum will be interactive and presented with in-person and remote attendance options.

The work will focus on what successes already exist, what local resources can be identified and creating sustainable partnership to make something happen for rural places and their people.

Conclusion

It should be noted that all of the ideas in this plan are based on data that are available and needs to be utilized in the opinion of the AHW team. We know the major causes of health issues and death in the United States, and we have the research on what we could do to change. Our past efforts were focused on a more top-down approach. We continue to work with our federal, state and local partners to address the structural issues that prevent good health and health care. This document now adds our present focus on a bottom up private/public approach to improving the health of our citizens.

We are now asking you to partner with us to bring about this major transformation in the health of our people. The AHW team believes that the use of a “healthier community” approach can and must be utilized to truly help America to become healthier.

“In these times, if ‘I’ is replaced by ‘We’ even illness becomes wellness”

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